

APPENDIX F

State of Nevada
Division of Public and Behavioral Health
Emergency Medical Systems Program

REQUEST FOR APPROVAL OF EMS CONTINUING EDUCATION

APPLICANT: _____
(Name) (Agency/Organization) (Day time phone #)

(Mailing address) (E-mail Address)

Continuing Education Topic
Start Date: _____ Date of Completion: _____
Curriculum: _____ Textbook to be used: _____
Location of Course: _____
(Physical address and building i.e. school, library, college, etc.)

Please indicate whether or not this course will be open to the public: ☐ Yes ☐ No

Please indicate whether or not you have access to training forms via the EMS Web page: ☐ Yes ☐ No

NOTE: This request must be submitted to the regional office at least 30 days prior to the anticipated start date. A course outline detailing class dates, times, topics and instructors must be submitted with this request.

COURSE COORDINATOR: I will be responsible for the instruction and presentation of the above course. I state that this course is within standards and compliance of Nevada Revised Statutes 450B and Nevada Administrative Code 450B. I understand that any omission of required information or misrepresentation will result in denial of approval and that failure to provide course completion material in the time allowed may result in denial of student certification and possible audit.

Signature (Sign in **BLUE** ink) Date: _____

PHYSICIAN OF RECORD: I have reviewed the course outline and list of instructors for this course and agree to provide medical direction for such. I will be responsible, along with the course coordinator, for the instruction and presentation of this course.

(Name: Please Print) MD Signature (Sign in **BLUE** ink) Date: _____

(EMS Office Use Only)	
Date Rec'd: _____	Recommend: Approval _____ Denial: _____
Reason for Denial: _____	
Course #: _____	Approval letter sent on: _____

Mail Request to: Bobbie Sullivan
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EMERGENCY MEDICAL SYSTEMS PROGRAM
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